

Medical Homes - Quality Metrics Subcommittee meeting 9.7.11

On the Phone: **Bernadette Roy**, CHC--Partnership Health Center; **Marie Hamilton**, Bozeman Deaconess Hospital; **Carol Kelly**, Bozeman Deaconess Hospital; **Cindy Stergar**, CHC-Butte Community Health Center; **Janice Gomersall**, American Academy of Family Physicians; **Kristina Davis**, Children's Defense Fund; **Doug Carr**, Billings Clinic

In Person: **Jonathon Griffin**, St. Peter's Medical Group; **Paula Block**, CHC- Montana Primary Care Association; **Bob Shepard**, New West Health Insurance; **Bob Marsalli**, CHC- Montana Primary Care Association; **Fred Olson**, Blue Cross Blue Shield of Montana; **Janice Mackenson**, Montana Pacific Quality Health Foundation; **John Hoffland**, DPHHS Passport to Health

The subcommittee began with a general discussion identifying the questions that need to be addressed: What data are we interested in? How do we get the data? What data repository do we use? What data is essential? What data poses issues to resolve? And what data might be nice to have, but can wait for later?

Some general comments made by members during the discussion are summarized below:

- There data repository may not be capable of gathering every data element so we will have to determine which elements are most important in discussions with the vendor after the selection.
- Harvesting the information will be the larger issue than the technology platform, so we will have to focus on what is most accessible.
- The data is not all of the same classification. Some are data elements requested are for tracking patient information and required as part of the provider's participation in medical homes and some are health outcome measures.
- It would be important to assimilate all data into one data base because having it is very important for picking up on data trends.
- Privacy is an issue that we need to discuss in regards to security settings One Vendor has a mechanism for de-identified data, for example, giving a birth date that is plus or minus three months.
- Techniques are available to de-identify data and are an important issue that we may ignore for now but we will have to work out with the data repository vendor as we progress with them. An external and internal ID could also be developed for patients. This could lead to even better metrics for quality care. More data and better security measures would be better than collecting less data out of concern for privacy.

The spreadsheet presented (and attached) includes data elements from 2008 and 2011 NCQA standards, combined into one collection since there was significant overlap. The committee worked down the demographic data or "general population reporting." The document was color-coded after the meeting to reflect the general consensus. The items in green (and bold) are the measures we definitely need to capture. The items in blue (and italic) are those measures we would like to capture but the data options are unclear. The items in maroon would be nice to have, but might wait for a later time. **These represent the decisions that were made by the subcommittee.** Comments on specific data elements are summarized below:

- Marital Status should be one of the data elements included. It needs to be inclusive of existing family patterns. Participants were asked to look in their EMR to see how that data is captured by them now
- Language preference is important for cultural sensitivity but may cause issues for data fields. The subcommittee decided to skip it for today as a desirable but difficult element.
- Race or ethnicity is often needed for grants and other data functions and should be included as a voluntary, self-identification. Census codes for this information is used as a standard by EMR's. Both this and marital standards are elements we need to look at the code base
- Address or telephone number, primary number and email address will all also be included.
- Internal or external ID needed to translate from the EMR to the data repository is often vendor dependent.
- Patient and family preferred method of communication is another element to be included. The subcommittee discussed whether we need fields for all the different methods such as sign-language and interpreters, text messaging, email, cell/home/work phone, etc. Bozeman Deaconess has a field in their data base for the patient's preferred method of communication which they can extract and report from texting. They ask this information on new patient demographic information forms. Bozeman Deaconess and other members will find out specifically how they handle this in their data base and report back to the subcommittee.
- Marital Status, Self-reported ethnicity, and preferred method of communication all need to be Reviewed for how the data is coded and stored and may need modification depending on the repository vendor's capacity.
- Emergency contact was decided as unnecessary element for the purposes of the repository, only for providers.
- Current and past diagnosis is an important element to be included. Clinical visits with other providers would need to be included and could be provided by the payers showing diagnosis, etc. The timeframe we would ask this for could be three years. Diagnosis and CPT codes should also be included.
- Hospitalization and ER visits should also be included in the data set although it would be incomplete. Case managers and care coordinators could have this reporting included into their job description so that hospitals and ER's are entering into the data repository. Whoever is doing case management needs notification when a patient goes to the hospital, the payer will know this fairly quickly. We will still need to work with the hospitals for extracting the data. We cannot overly-rely on the hospital visit data since it is incomplete. The vendors Fred Olson has talked with do not have this information on their data sets. A direct line of communication would need to be established with the hospitals to get the data and ultimately limit ER visits. In Billings Clinic they have the same electronic medical records and an encrypted email device that go through a message center versus regular outlook to communicate between inpatient and outpatient. In Butte the CHC retrieves this data from the hospital manually about once a week and it took nearly three years to establish this agreement. Bozeman Deaconess has a care manager that pulls records off of a portal that is for communication between the health groups and the hospital and they have a good relationship for exchanging this data although it is also fairly labor intensive.
- Due to the complexity of obtaining hospital and emergency room data, which is still likely incomplete, it was decided that this will be a phase II problem the subcommittee will tackle. Between phase I and phase II the subcommittee could work on some sort of strategy or initiative for making this issue of communication more efficient and comprehensive.

- Legal Guardianship information is important for children or vulnerable adults seeing multiple specialists and needing care coordination. Knowing the legal guardian could be very useful.
- Should there be an age parameter around the blood pressure element? Best practice would be blood pressure for everyone over age 18. Adolescents' blood pressure is not needed unless obesity is an issue.
- General measures for everyone – blood pressure, tobacco use, height/weight, BMI, possibly lipids, head circumference for children under 2. The quality metric should ask- what percentage of your patients are you capturing this data from?
- The subcommittee decided a data set needs to be established for tobacco use. Subcommittee members were asked to investigate: How does your EMR system capture this data and how much of this can you report on? How much is obtained by the clinic? If it is not obtainable then we cannot report on it? CHC's can get data on all the questions for smoking and alcohol use.
- It may be too difficult to find a technology platform that has all these fields. They are designed to provide roll up essential quality metrics, not perform as a complete EMR. The platform needs standard elements that are identifiable to avoid clinicians having to type them in manually. Smoking status and smoking and other tobacco use counseling should be on there as nice to ask but we will not start with it, we will wait until the data repository is selected. Quality measures are more related to whether the question was asked by the provider and whether the provider offered options or not.

Next meetings: September 14th 1:00pm, at CSI will be the first full advisory council meeting and the first meeting for the framework for payment subcommittee. September 28th both subcommittees will meet between 1:00 and 4:00 pm at a schedule to be determined.